Restructuring Medical Education

Medical education has not yet been critically reviewed and discussed in independent India. While doing so, the overall health situation of the country has to be taken into account and the structural as well as academic aspects of medical education should be considered. The decisions should be worked out in relation to three parameters: an extensive access to medical aid for every Indian citizen; different medical systems in India should be integrated with one another and professionalism should be balanced against social justice in a manner that neither is sacrificed at the cost of the other.

AMRIK SINGH

I

It is astonishing that, even after we became our own masters in 1947, we have not chosen to critically review and discuss the structure of medical education in India. While doing so, the overall health situation of the country will have to be taken into account. It is only in that context that the structural as well as the academic aspects of medical education can be reconsidered. As a student of education, I am inclined to put forward a few ideas for discussion.

The most important change made since 1947 is that, earlier there were two parallel courses, the Licentiate course and the MBBS course. In about a decade's time, the former was closed down and today we have only the MBBS course. In professional terms, this was certainly a step forward, but in the sociological terms, this was, however, a backward step as would become clear presently.

About the same time, the Chinese came up with the concept of barefoot doctors. There was some passing excitement, but then everyone forgot about it whereas the Chinese went ahead with the new structure of medical education and achieved a considerable measure of success with it. Not only that, the Chinese restructured their medical education in such a way that they integrated the traditional Chinese system of medicine with the allopathic system more or less on the proportion of 50:50. The homeopathic system has existed all along, but is not all that popular in that country.

The Chinese system of medicine as followed today in that country is not obsolete in any sense. On the contrary, almost every detail and dimension of it has been modernised and put on scientific lines. If one may venture to say so, our handling of the ayurvedic system and the Chinese handling of their traditional system is a study in contrast. If we are not prepared to look at it more closely than we have done so far, the fault is ours.

Crisis in India

The problem in India is that our medical graduates when they pass out tend to congregate into towns. Having been admitted through a strong competitive system, and undergone a fairly intensive course of instruction and training for four-five years, the doctors look forward to a good middle class career which is available only in towns and cities. What about the countryside? It remains seriously neglected so much so that even when primary health centres are established in some of the bigger villages, they fail to attract and retain the qualified doctors.

This has led to a crisis situation as far as the bulk of the Indian population is concerned. As per current figures, two-thirds of our people live in the rural areas. However, the trend towards urbanisation is growing. It will not be a surprise if, in another 10-15 years, 40 per cent of the people move over to urban areas. The issue, therefore, has to be seen from both points of view – the challenge of the overall population scenario and the need to prepare trained human resources both for primary health centres (PHCs). This is an issue which requires serious attention if we, as a nation, propose to change the existing structure of medical education. And that has to be done sooner than later.

II
Concept of Basic Facilities

The problem needs to be considered at two levels. If the countryside is to be given the same level of professional expertise as is available in towns and cities, this is likely to remain an idle dream and will not get realised in the near future. The medical aid in every country is linked with its economic and social development. While there is a good deal of talk about providing the same facilities to the villages as are available in towns, the painful fact is that, this is not going to happen so soon. In search of the ideal, we are failing to provide even the basic medical facilities that have to be provided.

It is important to define our concept of basic facilities both in terms of infrastructural facilities and trained human resources. In a situation when almost half the schools are not well housed, it would take quite an extraordinary degree of effort to provide what are called the basic facilities in the PHCs. The needs of a primary health centre are somewhat well defined by now. The fact, however, is that these facilities are not available to the bulk of the rural population and even in certain urban areas and all that we get is mere talk and very little action. Towards this end, three things will have to be attended to: (a) developing the potential for paramedical facilities in the countryside; (b) strengthening the potentially supportive role of the educational system; and (c) restructuring the medical instructional system.

It would be in order to take up (a) and (b) first.

Paramedical Facilities

The obvious thing to ensure is that, the requisite human resource power required for the purpose is by and large recruited locally to a possible extent. By now, except for the tribal belt, almost every village has a few educated women who have been married into that village and are going to stay there in the foreseeable future. It is this substantial woman power that can be identified, educated and trained in an organised and professional manner.

Going further, if one looks at the social composition of the village population, it would be found that more than half the village population consists of children at different stages of growth. In plain words, the frequent visitors to any primary health centre are women and children. Is it not possible to mount a programme whereby some of the more promising women who have some background of science education at the school level and are willing to learn are enabled to educate themselves further and given a paramedical orientation in what they are taught?

The other thing is that the more promising of them are given training in child care and midwifery right in that village. In some exceptional cases, they may be enabled to go to a nearby town over the weekend or for two-three days and equip themselves to become more competent in their chosen area of speciality. If some kind of an informal system of professional training can be organised for them, it would enable a few of these women to become properly trained midwives. Without doing something of this kind, it would be impossible to change the situation even marginally.

The fact is that even the teachers teaching in the schools that are generally found in the villages are not well-trained, in the problems of basic health care amongst other things. Could it be ensured that, even the children attending those schools will pick up these basics and acquire the right kind of habits? In other words, our school system itself needs to be given a specific health orientation so that those children who manage to go up to even the upper primary level begin to understand why is it necessary for instance, to keep food protected against microbes and why it is necessary to wash hands before eating and so on.

III
Strengthening Supportive Role

What we need in the countryside in particular is some local initiative and a certain amount of help from the department of health. In several parts of the country, wherever some initiative has been taken, it has led to positive results. What is lacking for the most part is the lack of support from the department of health which has some kind of an outreach programme more than anything else.

We should also look into the educational dimension. Unless we educate our teachers in the health matters and give them some basic training in this area of knowledge, the children who pass out will neither acquire the right habits, nor that supplementary knowledge which needs to be fortified further with an access to those programmes which are modern and also professionally adequate.

A programme to train a large number of midwives at different levels of competence is the need of the hour. A special syllabus needs to be devised for this purpose and it should be divisible into half a dozen modules. It would be perfectly in order if somebody were to take even three-four years even more, to qualify as a midwife. So much would depend upon her earlier background, her determination to succeed and her own family situation – for instance, is the mother-in-law supportive or are other women in the family (sisters-in-law and so on) prepared to share some of her responsibilities?

Some other inputs would be equally important. For instance, whether books of the right kind and level are available in the local language or not? If not, then the medium of instruction will be English but that will create an additional barrier in the way of self-learning. Some literature in Indian languages is already available and more and more of it can be easily prepared and published. While technical terms may be the same as are used in English, the rest of the material will have to be written in simple, straightforward prose in different Indian languages. This is a job which can be handled at the state level either by anyone of the existing agencies or an agency exclusively created for it. The important thing to ensure is that village women are persuaded and enabled to get involved in the enterprise. But, they cannot leave their children behind and go out. Therefore, they have to be educated where they are. In certain cases, they may go out over the weekend or maybe for a day or two, but it is rare. Therefore, it is crucial that the kind of information that has to reach them is provided to them wherever they are situated. Perhaps some of the open universities can play a supportive role in this matter. Normally they operate at an advanced level but they possess the right kind of presentation technic which can be made available to those who are commissioned to prepare literature for these new trainees.

In addition to involving some of the young and semi-educated girls from the village, a certain amount of involvement of how teaching is done in schools is equally important. While children are too young to understand the causes of diseases and what precautions to be taken and, it is important, as already stated, that they acquire the right kind of health habits. Both the parents and the teachers have a role to play. In the case of the teachers, as of today health education is not a part of their training. But, the teachers need to be given that kind of health education.

In every society whether, primitive or modern, adults come to acquire a certain kind of attitude towards health and disease. No individual is able to function without this kind of understanding. If education is to have any meaning in daily life, some basic education about the basic principles of health has to be an integral part of it. When our teachers come to acquire a different kind of orientation about the problems of health and disease things will start changing.

The specialised medical education comes much later in life. What one learns in the beginning are the basics about health and disease. And it is some kind of advanced specialisation about a few of those items of knowledge which ultimately prepares one for entry into the medical profession. To see a close and intimate connection between education and health and disease is something so self-evident that not to give it greater importance than what is happening today is to refuse to learn from our experience.

The third dimension is no less important. The proposal to train almost half a million midwives was made by the Planning Commission some years ago. It was regarded as a useful suggestion but very little got done because of lack of coordination. The feeling amongst the local semi-trained

persons that they can be educated further and the provision of appropriate health and teaching facilities demand a certain amount of coordination among the various agencies of the government. The Planning Commission can only favour such an approach but the actual job has to be done by the state governments. Most of them are expected to function in a broadly cooperative way so that coordination amongst the different agencies of the government does not remain a distant dream. An NGO activity is useful insofar as it exerts pressure upon these different agencies which in turn leads to better productivity and better health service. To mobilise the department of health to coordinate with these other agencies is, therefore, an important input and needs to be ensured to the extent possible.

IV
Restructuring the Medical System

Having discussed some of the preliminary issues, it is time to come back to the basic issue. How is it that the British when they introduced the system of medical education in India decided to split the job into two parts, the licentiate system and the MBBS system? If one may venture to say so, this was in recognition of the social reality which they encountered in the country. The bulk of the people followed the traditional system which differed from one part of the country to another. The most popular of them was the ayurvedic system, but there were other versions too. Even today, more than 200 years after the western system was first introduced, almost three-fourths of the people still follow that system.

When the British decided to introduce the western system of medicine into India, they made a pragmatic decision. For the sake of convenience, we can call it as the introduction of a full-fledged medical degree which was broadly comparable to the first medical degree in other western countries. It is known for instance, that there were some problems of academic equivalence between the British MBBS and the Indian MBBS. The British professional opinion was reluctant to equate the Indian MBBS degree with her own MBBS degree. That indeed was one of the reasons why the Indian Medical Council was set up in the early 1930s . The courses, ran parallel to each other for more than a century. In the 1950s, when things had somewhat settled down after the transfer of power, the Indian Medical Council came up with the proposal that the licentiate course be discontinued and everyone should be required to do the MBBS course. The basic difference between them lay on the amount of preparation that had to be undertaken before seeking admission to both the courses the MBBS course required more advanced preparation before admission than in the case of those who sought admission to the licentiate course.

Even when the decision to discontinue the licentiate course was being made, some people had reservations. The Indian Medical Council however was determined not to be seen as lagging and that is what happened when the decision to do away with the licentiate course was enforced. It is purely a coincidence that it was about that time that the Chinese system of barefoot doctors came to the picture. For their part, the Chinese had recognised for themselves that, since the social situation in their country was uneven, the kind of medical aid provided to the public had to be considered. What is more, the concept of the barefoot doctor called attention to another dimension of the problem.

In any primary health centre, 80-90 per cent of the problems for which people seek medical attention are of an elementary kind. That is why, even in a PHC, an assistant can help if the doctor is not available. In other words, the concept of a barefoot doctor is based on this recognition of the reality that it is only 10-20 per cent of the patients who require advanced or specialised attention. The rest of them can be handled in ways much less demanding in respect of medical knowledge and expertise.

But so determined were we to do what the advanced countries were doing that we decided to go ahead by discontinuing the licentiate system. It is also time to take note of another change that was also taking place. There is a greater emphasis on the Indian system of medicine now. Till then, the ayurvedic system had been looked upon with disdain by the medical establishment. It was only a few committed people who thought well of the ayurvedic system. In a few cases, some of its striking achievements had compelled special attention for it.

Once a member of the Indian cabinet told to me, "While 80 per cent of the funding goes into the allopathic system, approximately the same percentage of people patronise the ayurvedic system". His statement may not be exactly accurate but we can take it to mean that the Indian system of medicine could not be brushed aside as had been happening even a couple of decades earlier.

To go into further details, after 1947, the situation began to change. Two developments may be noted in this connection. One was the increasing official patronage extended to the Indian system of medicine and the second was the growth of the private sector in medical education. The private sector in medical education has not grown in the same extensive way as in the case of technical education, but it has grown to quite an extent. Even the Indian Medical Council Act was amended around the 1980s partly in order to take note of the changing situation. In plain words, what had happened was that more and more people had been going for medicine and the establishment of a fairly active private sector played a helpful role.

In order to establish medical colleges, a hospital has also to be established. This put a severe constraint on the establishment of such initiatives. But for that single factor, the professional, standards would have gone down steeply as they have in the case of technical education. What requires to be noted is that, apart from the patronage extended by the central government which has been somewhat halting and niggardly, the Indian systems have failed to attract the right kind of talent.

Consequently, the kind and quality of research done in the Indian systems is not all that satisfactory though it must be added in all fairness that the manufacturing sector in the field of the ayurvedic medicines has registered a phenomenal degree of growth. But why not compare the situation to China? In that country, as stated earlier, the traditional system has been adapted and modernised extensively with the result that it virtually constitutes one half of the main syllabus of their basic medical degree.

In our country, we have several parallel systems of medical education. Every speciality has a different set-up. The conditions of entry are different and so are the quality of the teaching staff and other facilities. Indeed everything is different, so much so that a kind of pecking order has got established and the allopathic system stands at the top. This was by and large avoidable. How this disparity can be evened out is a long and complicated question. It will also have several significant implications in respect of the health system as a whole and also as the system of medical education. In fact, not everyone would even agree with the desirability of

doing away with these distinctions. But one of these days, these distinctions will have to go. To say anything more than that at this stage should not be necessary.

V
Medical Instructions

What are called the basics have to be studied by everyone. Every medical student has to learn both hygiene and physiology, for instance. It is mainly the 'materia medica' in each case which is different. The emphasis on surgery also varies. The Indian system of medicine as it has come down to us does not attach as much importance to surgery as for example, the allopathic system does. It was the continuation of the neocolonial attitude which more or less made us look down upon the Indian medical systems and rate them as inferior to the allopathic system. This is not the only factor at work. The Indian systems of medicine as these have been practised for a long time have not undertaken systematic research as is being done all the time in the allopathic system. Nor have the auyrvedic medicines been standardised in the way the allopathic medicines have been for quite some time. Had we gone into these matters more systematically and more thoroughly, the situation would have been different by now. Even if we decide to push ahead for a decade or so today the situation would undergo a remarkable change.

In this connection, it may not be out of place to mention what the Russians have been doing all this time. They have one system of medical instruction and both allopathy and homoeopathy are covered by it. Every medical student is required to learn both the systems. Then it is left to the doctor to choose the system which he prefers to use. Put another way, the Russians have not chosen to put a premium either on allopathy or homeopathy. They regard both as equally worthy of attention and leave it to the doctor to choose either of the two systems.

Another fact which needs to be mentioned is the alternate medicine. This concept has not been defined in any precise way. But it is widely known and recognised that, in certain cases, acupressure can achieve certain remarkable results, which cannot be overlooked. It is, therefore, well accepted that the acupressure system may be used in certain situations as a supplement to whatever be the line of treatment being otherwise followed.

The more relevant thing to say is that what is called comparative medicine hardly figures in any medical course. There are several systems of medicine available around the world. While some research is being done with regard to their comparative curative qualities, this particular branch of study has yet to be formalised in academic terms and promoted. As of today, the health policies are being formulated by people who are educated mainly in the allopathic system. They, therefore, discuss and decide things in terms of what they know and are virtually ignorant of what is happening in other comparative areas. What is required is that policy-making in the medical field is not monopolised by any group of people. Indeed, there should be an openness of approach about it. That is not happening and this needs to be changed.

To sum up, the following steps need to be taken. It will be years before they actualise but there should be a certain degree of acceptance that they need to be taken.

One, the system of medical education should be the same for everybody. About two-thirds of what is included in the medical syllabus is useful, indeed indispensable, for every category of medical person. More than that, when we look at the experience of other developed and developing counties like China, Japan, US, UK, Russia, France, Germany and so on, we cannot but notice one thing. The medical education attracts some of the more talented students. This is happening in India also. But, for the most part, they generally opt for the allopathic system. This, therefore, impoverishes other branches of medicine. Both in order to grow as a nation and to promote our own systems of medicine, it is important that this trend is gradually modified. That alone will ensure that our medical systems also receive a fresh and continuous input of talent.

Had that started happening even after 1947, the situation would have been decidedly different by now. This is said on the assumption that there is something in each system. Only the professionals can investigate the question what requires to be incorporated into the current body of accepted medical knowledge and what requires to be rejected.

Two, there can be and ought to be variations in the system of medical instruction. Some students will opt for one option and some for another. To begin with, the non-allopathic options will be at a disadvantage. But with a change of policy and increased patronage and support to our own systems of medicine, things will start changing. This means that, every couple of years, the situation will have to be reviewed somewhat formally and the priorities re-determined. Apart from the initial resistance, the going will remain tough unless, as a matter of policy, a determined attempt is simultaneously made to divert talent into the new channels.

Three, parallel to changes in the system of medical instruction, urgent and systematic attention will have to be paid to the standardisation of Indian drugs. This area of research as also the nature and extent of government control over the manufacturing of drugs and their safety of production and distribution has not received the attention it deserved. A decade of intensive attention will lead to far-reaching changes which in turn will impact upon everything connected with the manufacturing, testing, fake drugs, intellectual property rights and a dozen other things.

Another outcome of all this reformulation and redesigning of policies will have far-reaching implications in respect of human resources planning. Those are proposed to be discussed in the next section.

VI
Human Resource Planning

It is time to come back to the issues raised by the concept of the barefoot doctors. The issues raised were basic in character and exceedingly important. But we preferred to ignore them and continued with our elitist and self-serving policies of medical education. In professional terms, what was happening was perhaps in order. But we did not stop to answer one question: is it in tune with our social situation and our health requirements?

One thing that has emerged clearly from the foregoing discussion is that there are three levels of population which need to be recognised and dealt with in terms

of the ground situation. One of them was referred to in the beginning. Those living in villages who have had a bit of science education and also have some natural curiosity can be helped to acquire greater professional expertise provided we move in the direction of providing paramedical instruction to those women and men, and in this order. This is on condition that they have some kind of inclination to receive further training and acquire the minimum amount of medical competence which would take care of the problems faced by the majority of women and children.

Some of the men can also play this role. Those of them who are willing to learn can be given a paramedical training. As stated earlier, the whole thing has to be organised in terms of half a dozen instructional modules. While men might be able to leave the village and travel a few miles everyday, if required, women have to be given training in the village itself and that too during those hours of the day where they have attended to their daily chores and have some spare time. In either case, some kind of elementary training have to be arranged in the village itself. If such a system can be evolved with the help of the distance education mode of teaching and the co-operation of the department of health, it should be possible to train something like a million paramedical persons in about a decade. This is the key issue on which the success or failure of what is proposed will depend to a great deal.

The job looks immense and indeed it is so. What it requires is a couple of thousand trainers who possess a certain minimum amount of professional expertise which they can then impart to others and are also prepared to travel around . Once the system begins to catch on, there would be more and more people wanting to join this new initiative than perhaps it would be convenient to handle. The crucial thing to do is to train and organise what are called the master trainers. More than half of them will have to be women and the rest can be men.

When it comes to employment, a certain number of women can work on their own in their private capacity whereas the bulk of men can be engaged in some semi-professional capacity or the other at the PHC level. About one-third of the villages have such so-called centres. They have some facilities, but those leave a lot to be desired. If more such villages could be given the PHC facilities it would become possible to take care of those medical complaints which cover 80-90 per cent of the individuals going to these centres.

The concept of the modules of training may be re-emphasised. A new kind of mechanism would have to be established to grade, classify and award these modules. Given our talent for diluting all such initiatives, there can even be corruption and so on. But, once we are conscious of what is involved, steps can be taken to regulate the initiative and protect it against corruption or dilution of any kind. It should not be necessary to provide further details but many more than those provided here will have to be examined. In a sense, paramedical training as proposed above is as important as the spread of universal literacy. To some extent, these two are also inter-related.

VII
Role to Perform

Then will come the next stage where those who have completed part A of their formal medical training and are now given a job and a role to perform. They would have been trained reasonably well and would be able to handle 5-10 per cent of even the difficult cases. At this stage the focus would have to shift from the PHCs to small hospitals. These hospitals would have facilities even for anaesthesia, etc, in certain cases. The medical students would have received some training in certain selected fields of their choice. For instance, one person might specialise in the use of anaesthesia and another in the testing of eyes and so on. In the minimum, they would be able to take care of somewhat difficult, but not necessarily complicated cases.

While some of the students would be anxious to get back and complete the medical degree, this may not be true of every one. In any case, the important thing to keep in mind is that there are different levels of medical help required and different levels of facilities would have to be provided. Even hospitals can work at different levels. Some of them, for example, may deal with simpler cases whereas others would require specialised training as also special facilities. One problem with most decisions taken in respect of public health as also medical education have suffered from this infirmity that the concept of different levels of medical problems has neither been understood clearly nor implemented intelligently enough.

To elaborate this particular issue no more, the system of health care would have to be organised broadly in terms of what has been sketched above. It is not the Planning Commission or the centre which will play the decisive role. The centre can at best provide more funding and encourage the state governments to go ahead with this kind of arrangement, but the basic job, will have to be done by the state governments. They are not accustomed to dealing with such problems as have been described above. More than anything else, they require an imagination as well as flexibility. Therefore, the centre would have to do a large-scale job of involving the policy-makers at the state level in a series of workshops. No more details are being provided here because this argument is not about the new health policy, but about restructuring the system of medical education.

It is in terms of the basic structure of the health management system that the restructured system of medical education can be formulated and also implemented. To recall, a broad threefold management division has been suggested. The first level will consist of the lowest layer of the population. The state can help partly by imparting the local people with imparting the expertise of certain kinds of paramedical training and partly by providing medical facilities. A certain proportion of the villages may have PHC centres as well, which can be equipped better and also increased in number. But it would not be easy to provide trained human resources from outside.

The second level of population is to some extent served by the PHCs, but poorly. Their biggest weakness is the lack of professionally trained human resources. Once the two proposals made above are accepted, the situation would begin to change. By including the different systems of medicine under one broad heading, both academic and sociological outcomes would follow. Those cannot be gone into here, but the existing state of hostility and distrust among them will begin to undergo a change. Secondly, there would be a greater give and take amongst them.

To some extent the situation would differ as between rural and urban areas. The latter generally have PHCs. Only they are often not well-equipped or well-staffed. A plan to train such people as have had paramedical training would have to be drawn up. In addition to doctors, the paramedial staff is equally important. Unfortunately, this sector of work is largely neglected today.

The third level would broadly correspond to what obtains in towns and cities today. There are general practitioners and a good number of specialists. Both will continue to flourish and also expand and diversify. But no one should overlook this fact that the existing system leaves out substantial sections of the population from its ambit and is therefore, sociologically unjust. Once things begin to change at the two lower levels, these will in course of time influence what happens at the third level.

It is against this background that the proposal to restructure the duration of the medical course by a mandatory interruption of two years requires to be seen. For one thing, it will prolong the duration of the course which will have its own important implications. For another, the field experience will have its own educative impact. The medical students will not stop learning during those two years. When they return to the classroom, they will be significantly more mature and better able to absorb what they are instructed in. Several other kinds of changes can also be visualised. One of them at any rate requires to be mentioned.

Amongst other things, the career graph of the medical profession needs to be remodelled. Today, there is only one model of career growth. Under the changed system, while the existing career pattern will by and large continue to prevail, that would not be uniformly true. A certain proportion of them will adopt different patterns of growth. And that is urgently required. Today, only the needs of the affluent category of population are being served. Those who are less affluent have to go through a good deal of deprivation of medical services and that is something which cannot and must not be overlooked.

VIII
Counter-Arguments

Whatever might be said in its favour, opposition to this proposal will be widespread. More than anyone else, it is those who control policy-making today who will oppose the change. An important part of their opposition would be rooted in their reluctance to give a higher status to the other systems of medicine. That these systems are not up to the mark today and are lagging the allopathic system cannot be disputed. But the issue of what is medically valid in what they recommend and to what extent they are scientifric and consistent in their approach are amongst the problems that will have to be examined. The existing situation in which the other systems are ignored is neither scientifically in order nor in consonance with our sociological situation. As stated earlier, three-fourths of the Indian population is treated by the practitioners of non-allopathic systems. Therefore, to ignore them is out of question. A way to merge the different medical systems has to be found. Something along these lines has been proposed above. But the job cannot be done without restructuring the existing system of medical education. It is in recognition of the gap between our academic and social planning that two things have been suggested.

The first one is to make the MBBS syllabus not entirely allopathy-based, but a combination of several other systems. This particular proposal is bound to encounter considerable resistance. As stated above, it is those with the background of

allopathy who control the policy-making and look down upon the ayurvedic as also the other systems. The ideal to be aimed at should be that the other systems too require to be inducted into the medical syllabus. How soon this is done and in what manner and proportion are matters of professional judgment. There should be no disagreement with the proposition that something like what the Chinese have done has to be done in our country as well. The situation in both countries is more similar than dissimilar. Once again, details cannot be specified but these are issues that need to be discussed, adapted and, sooner or later, put into effect.

The second proposal also marks a break with the existing system insofar as it is proposed that the MBBS course is split into two parts. Part A (with its focus on the basics) should take three years after which the students have to, as a part of their academic commitment, spend one year in a village and one year in a small town and acquire practical experience. After that, some of them might decide to discontinue their study altogether or postpone it for a while and accept lower category jobs meanwhile. Perhaps a larger number, something like two-thirds, would continue with their degree and may be less than half of them would later on also go on for super specialisation in different areas. Each one of these suggestions is bound to have a sociological impact also and the matter would have to be kept under review all the time. The basic objection to the existing system, as stated earlier, is that there should be three and not two categories amongst those who are involved in the job of providing medical aid.

The lowest category will be, by and large, rooted in the soil to a large extent as described in the beginning. The second category will consist of those who are specially trained for the job at the paramedical level or those who receive training for three years when they join the medical course. Some of them, it is assumed, will continue to work and not immediately go back to the interrupted course. These are some broad ideas and the issue requires to be discussed by professionals as also others who are interested.

IX
Conclusion

Instead of dilating further upon the points already raised, it would be more to the point to redefine the issues already raised. (a) There has to be a clear sighted recognition of the fact that there are three distinct categories of the Indian population. Those at the bottom layer cannot be helped from the outside. For the most part, local efforts would have to be made to make them self-reliant. The danger mark is the high infant mortality rate in some of the more backward states. That is why most of the emphasis is on training village women to understand the whole business of child birth and early childhood care and make the villages as self-reliant as possible. (b) At the next level, it is visualised that the coverage of the PHCs would be increased as also given a greater paramedical edge. Some specialised training programme for that purpose would also have to be undertaken. For the rest, the main job would be done by those who complete part A of the restructured MBBS course. Since it is also visualised that this course would be enriched by drawing upon the resources and insights of the other systems of medicine, it would virtually amount to creating a second level of professional expertise.

Without creating a secondary level of experience (in plain words, creating and sustaining a degree of medical expertise which falls short of specialisation), the needs of the urban poor will not be met. In this context, those who now opt for the other systems of medicine can get drawn into this category of professionals, provided the comparative approach is actively promoted and the non-allopathic branches of medicines are not treated as inferior by those who control the profession at the policy level today. By assimilating them into the mainstream of the profession, we would be moving in the direction towards which we ought to move. Also, this will attract fresh layers of talent into the profession. This is badly required, if one may add at this stage of the argument. Will this happen?

The answer will depend upon two factors. One, the political will of those who formulate and implement medical policies. Secondly, how do the leaders of the profession adjust to the changing policies as also the fact that they are prepared to re-learn some of the basic elements of their profession? The sense of superiority with which the current leaders of the profession, particularly those who control the Indian Medical Council, participate in the argument would be a lesson by itself. Perhaps half the battle will be fought over conceding a certain degree of parity to those who follow the other systems of medicine today. At present they are not even treated with the kind of respect with which a civilised argument has to be conducted. To say anything more than this should not be necessary. But if medical education has to be restructured, this battle will have to be fought in the manner already described.

The ravages of the system now in force were not clear at the time the licentiate course was discontinued half a century ago. By now, it is clear that the same-degree-is-good-for-everybody approach is not sustainable. How and where exactly we agree with one another remains to be seen.

(c) At the third level, not too many changes can be made except that the MBBS course is split into two parts with a mandatory two-year period of interruption during which field experience is acquired. This will inevitably enrich and transform the character of the MBBS course. The MBBS course must proceed as at present, but it should not be pitched so high that the bulk of the population cannot make use of the medical expertise that some of them will acquire. That expertise is required. A few medical graduates will also opt for what are called super specialisations. If the proportion of such persons is more than 10 per cent or so, that will create some degree of imbalance. Elitism of a certain kind is required but, if it is carried too far, it will create problems that do not have to be elaborated here.

(d) What the Chinese have done needs to be studied in much greater detail than has been done so far. Their achievement in being able to integrate their traditional system with the allopathic system requires to be studied by our specialists. If the experiment is found to be successful, as is generally believed, there is no reason why we should remain west-oriented only.

All changes that are made should be worked out in relation to three parameters of decision-making. The first one is extensive, if not universal, access to medical aid for every Indian. Secondly, the different systems of medicine should be integrated with one another in such a way that professionalism does not suffer in any way. But equally important is that, professionalism is balanced against social justice in a manner that neither is sacrificed at the cost of the other. EPW

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